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UNIVERSITY OF ALBERTA

DEFINING AND DIAGNOSING CO-DEPENDENCY: CONSTRUCTION AND VALIDATION OF A CO-DEPENDENCY TEST

BY

LAURIE ANN SIM

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION IN COUNSELLING PSYCHOLOGY.

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

SPRING, 1991

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UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Defining and Diagnosing Co-dependency: Construction and Validation of a Co-dependency Test" submitted by Laurie Ann Sim in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

E. E. Fox

E. A. Conn-Blowers

Bernard Schwartz

Date: 24 April 1991

for Devin, who is my inspiration

ABSTRACT

All current co-dependency literature which could be accessed was systematically reviewed. Extracted from this literature were 11 basic reference sources to which the major part of the literature was dependent. These 11 sources were content analyzed for descriptors of co-dependency. This process yielded 117 descriptors. It was found upon close examination that 14 rubrics could be employed to name categories under which to subsume the 117 descriptors.

At this point, 174 items were generated such that each of the 14 named categories were represented. As well, each category was represented in accordance with the incidence of citation of it in the selected 11 sources.

From these initial 174 items, American Psychological Association recommended procedures were followed to constitute a 100-item co-dependency measure. The 100-item form was administered to 178 people so selected to represent a stratified sample of the socioeconomic range common to Canada and specifically Alberta. An item-total correlation revealed that an economical, valid version of 60 items could be constructed from the initial 100-item version.

This 60-item version was dubbed the IOT (Individual Outlook Test) so as to not prejudice the testee by calling it a Test of Co-dependency.

Internal consistency estimates were generated and revealed a Cronbach's alpha coefficient of .88. A test-

retest reliability estimate of .89 with a standard error of measurement of .33 was derived and a small research project was conducted where 18 professionally diagnosed co-dependents were compared to a matched group of "normals" drawn from 107 "normals" in a larger sampling of the population.

It was concluded that the IOT is a reliable, valid research and clinical instrument.

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CHAPTER I

Introduction

"The concept of codependency is gaining popularity. There are numerous articles and workshops devoted to it. The term is used in popular parlance, by professionals, by patients and by members of the families of alcohol and other drug dependent persons" (Gierymski & Williams, 1986, p. 7). What is co-dependency? Who is a co-dependent? What are the criteria for diagnosing co-dependency? Most importantly, does co-dependency exist as a diagnosable entity? Until now, only subjective judgements have provided the basis for assignation of the label 'co-dependency'. What is desperately needed is a sound psychological instrument to assist the helping professions to more accurately diagnose the existence of co-dependency (Jackson, M., Counsellor, Alberta Alcohol and Drug Abuse Commission, personal interview, 1990).

Co-dependency has been defined as a specific condition which arises as a consequence of long-term exposure to an alcoholic or chemically dependent individual. A second, broader view holds that co-dependency evolves from lengthy exposure to any dysfunctional environment. In both cases the individual has learned a set of behaviors which are functional (i.e. survival-oriented) for the condition in which they were

learned; as adults, however, these same patterns of behavior may cause severe relationship problems and in some cases constitute a serious health hazard.

This paper is concerned with the broader view of co-dependency which is defined as:

> an emotional, behavioral and psychological pattern which develops as a result of prolonged exposure to and practice of a dysfunctional set of family rules. In turn, these rules make difficult or impossible the open expression of thoughts and feelings. Normal identity development is thereby interrupted (Subby, 1987, p. 84).

This notion of co-dependency came about as a consequence of many years of clinical observations in the alcohol/chemical dependent field (Subby, 1987, p. 9). What is glaringly absent in this abundant literature is quantitative analyses of these clinical observations. Indeed, the existence of co-dependency has been assumed and assessment and diagnoses has been the subjective decision of health care workers in spite of calls from some, notably Cermak (1986a) who warns, "The process of pathologizing human behavior is dangerous and should be entered into only under the weight of compelling evidence" (p. 100).

This lack of objectivity may be due, in part, to the controversy which generally attends the emergence of a new concept. In the co-dependent field, a major source of this confusion is the etiology of co-dependency, and

the consequent development of a working definition. As well, depending upon perspective, co-dependency could be conceived of as a disorder, a disease, a concept or an addiction. Herein, as a preliminary contribution to the task at hand, will be an attempt to isolate co-dependency as a psychological construct.

Therefore, creation of a scientifically validated instrument to diagnose co-dependency will not only provide a much needed assessment tool but will afford evidence that co-dependency exists as a recognizable entity.

CHAPTER TWO

Review of the Literature

Early Research

Co-dependency as an area of specialization is very recent (Schaef, 1986, p. 1); it evolved from a long history of research in the field of alcoholism. This early research focussed predominantly on wives of alcoholics; of interest was whether these women were psychologically disturbed prior to marriage or became so as a consequence of adapting to life with an alcoholic. Edwards 'et al' (1973) offer a review of the various arguments. While some of the research cited involved clinical impressions and subjective reporting, many were scientifically-oriented. Although there have been many criticisms of the methodology employed in this early research including the lack of longitudinal data and problems with the sample selections and sizes, some of the descriptors of these wives are strikingly similar to those seen in contemporary co-dependency literature. Interestingly, no identifying profile similar to that of co-dependency as it is known today was reported; this may be due to the fact that the emphasis of this research rested on the wives in terms of their husband's alcoholism and not as a mutually exclusive condition.

Price, for example, as early as 1944 describes wives

of alcoholics as dependent, insecure individuals who lack a sense of their personal boundaries. These same descriptors can be found in Beattie's (1987) comprehensive compilation of co-dependent characteristics as well as other recent co-dependency literature (Mendenhall, 1989b, Schaeffer, 1987; Smalley & Coleman, 1987; Subby, 1987; Cermak, 1986).

It is noteworthy that this early research is, for the most part, disregarded in modern co-dependency work both in terms of their findings and in terms of their interest in scientifically-oriented research.

Contemporary Literature

Lack of Scientific Rigor

Contemporary co-dependency literature is controversial and, as indicated earlier, lacking in scientific methodology; if quantitative research exists it is elusive. Information to date is derived from clinical observations, informal retrospective case studies, anecdotes, and testimonials from the helping professions. The emphasis in the literature is on treatment; self-help books and articles discussing treatment modalities are the rule. Subby's (1987) book, "Lost in the Shuffle" is typical of the genre in that it exemplifies the continuing trend in the field of co-dependency to disregard scientific rigor. Like the

majority of writers in this area, Subby presumes the existence of co-dependency and concentrates his efforts in favor of descriptions of etiology, behavior patterns and treatment programs. He bases his insights on his clinical work in the chemical dependent field as well as his personal experience as an alcoholic and co-dependent.

Norwood (1985), like Subby, accepts the existence of co-dependency as a given and indicates no interest in the application of scientific methods to the field. She describes co-dependency, its etiology and treatment from an information base which included "hundreds of interviews with addicts and their families" (p. xiv), as well as her personal experience as a co-dependent. Presumptions of the existence of co-dependency and a reliance on clinical observations are also seen in Whitfield (1989), Smalley & Coleman (1987), Young (1987) and Cleveland (1987) to name but a few.

There is, however, a slow movement toward an interest in scientific concerns. Wilson Schaef (1986) is one of a few who addresses the application of scientific methods to co-dependency. Implicit in her discussion is that objectifying co-dependency would be to exhibit characteristics of co-dependency (i.e. control and rational, linear thinking).

In 1989, the Potter-Efrons published a questionnaire developed to assist in assessing co-dependency. This tool consists of a number of questions designed to elicit information and provides what appears to be an arbitrary cut-off to determine the presence of co-dependency. There is no reporting of the process used to create the instrument and one is left to assume that no psychometric methods were applied. However, this attempt to create a diagnostic tool would indicate that the authors see a need for the development of standardization in assessment.

Friel (1985), a counsellor working in private practice, made up his own set of questions of what he thought constituted co-dependency. He requested other counsellors to use his test to ascertain its utility and to obtain data which he hoped to use to create a psychometric instrument. He violated many of the American Psychological Association procedures for test construction as outlined in the APA Standards for Educational and Psychological Testing (1985). Still, future researchers should know of this attempt as it may have some value for understanding co-dependency.

Cermak (1986a) clearly calls for the application of scientific methodology to the field of co-dependency. He states, "Unless we can begin gathering reliable and

valid research data, co-dependency will remain confined to clinical impressions and anecdote" (p. 3). Interestingly enough, Cermak's proposed incorporation of co-dependency as a Mixed Personality Disorder in the DSM III [R] to provide a standardized base for research was gleaned from his clinical impressions.

Gierymski and Williams (1986) agree that quantitative research is needed. They question the diagnosis of co-dependency when there is no quantitative support for its existence and argue that, "the use of the term `co-dependent' [is] not culled from any systematic studies. They are bare assertions, intuitive statements, overgeneralizations and anecdotes" (p. 7). Their concern with this lack is clear when they say

> . . . the term is voiced insistently by well-meaning supporters of co-dependency who often help to shape the policies and practices of local treatment centers, who influence public opinion and who propagandize the view that there is a specific, identifiable and treatable syndrome of co-dependency (p. 7).

Gierymski and Williams do not address the consequences to the client of misdiagnosis and/or negative labelling, both of which should be of concern to the conscientious diagnostician. To label, correctly or otherwise, without benefit of a valid, reliable instrument is irresponsible.

Etiology of Co-dependency

A plethora of definitions of co-dependency have been proposed over the past few years. Each share a common view of the manifestations that arise from being co-dependent; dissension occurs, however, as to its etiology of which three views permeate the literature.

Co-dependency and the Alcoholic Family.

Initially, the terms `co-dependency', `co-alcoholism', and `enabler' were used interchangeably to describe clusters of dysfunctional traits and behaviors shared by spouses of alcoholics (Gierymski and Williams, 1986) and other family members (Wegscheider-Cruse, 1985). Much of the literature continues to hold that the etiology of co-dependency arises as a consequence of exposure to an alcohol/chemical dependent environment. (Mendenhall, W., 1989a; Mendenhall, W., 1989b; Asher, R. & Brissett, D., 1988; Bogdaniak, R. & Piercy, F., 1987; Rekers, G. & Hipple, J., 1986; McConnell, P., 1986; Mapes, B., Johnson, R. & Sandler, K., 1985; Woititz, J., 1983 and Deutsch, C., 1983).

Co-dependency and the Dysfunctional Family.

Simultaneous to this train of thought, albeit not as prolifically discussed, was the notion that co-dependency was more than alcohol-related -- that, in fact, co-dependent behaviors may arise from exposure to

any dysfunctional family including alcohol and/or chemical dependencies. The types of dysfunctional families which these clinicians believed created co-dependent behaviors are many and varied. (Whitfield, C., 1989· Beattie, M., 1987; Smalley, S. & Coleman, E., 1987; Young, E., 1987; Cleveland, M., 1987; Subby, R., 1987; Schaefer, B., 1987; Mulry, J., 1987; Wilson Schaef, A., 1986; Cermak, T., 1984; Gierymski, T. & Williams, T., 1986 and Peele, S., 1975). Beattie (1987) describes a family system with "sick, disturbed or troubled people" (p. 36) as perpetuating co-dependency, while Young (1987) discusses one "that is repressive and oppressive . . . " (p. 258). Subby (1987) lists four main family systems which stand out as prime breeding grounds for co-dependency:

> (1) alcoholism and chemical dependency family systems, (2) emotionally or psychologically disturbed family systems, (3) physically abusive/sexually abusive family systems and (4) fundamentalist or rigid, dogmatic family systems (p. 10)

Mulry (1987) adds systems in which compulsive gambling, compulsive sexual activities, some eating disorders, incest and family secrets exist (p. 215). Gierymski and Williams (1986) suggest that co-dependency may also arise from "families with a chronic disease,

such as schizophrenia, diabetes, Alzheimer's or mental retardation . . . " (p. 12).

Although Wegscheider-Cruse (in Wilson Schaef, 1986) emphasizes as high risk those groups associated with alcoholism and chemical dependency such as "spouses of addicts; recovering addicts; adult children of alcoholics" (p. 43), she has also added "young children with workaholic parents, grandparents, or siblings; and professionals who work with addictive persons" (p. 43). In addition, she includes "families with a secret or trauma, families that do not foster autonomy and families that reward learned helplessness" (in Wilson Schaef, 1986, p. 43). Larsen (in Wilson Schaef, 1986) indicates that co-dependency may arise from living with a neurotic (p. 43). Of interest is Wilson Schaef's (1986) belief that the presence of co-dependency itself will lead to family dysfunction which, in turn, promotes the intergenerational transmission of co-dependent behaviors. Thus, it would appear that co-dependent behavior patterns may arise from contexts other than those in which alcoholic or addictive behavior occur.

Co-dependency, the Family and Society.

Indeed, Peele (1975) agrees that co-dependency can arise from other than alcohol-related environments. He writes that the family has "a tremendous impact on our

[potential] since they teach us either self-confidence or helplessness, self-sufficiency or dependency" (p. 6). He goes further, however, in citing etiological factors which may lead to co-dependency. Peele argues that our culture with "the dominating influence of institutions" (p. 153), including advertising and media which promote the use of addictive agents and emphasize personal deficiencies, reinforce feelings of low self-esteem, impotence and dependence learned in the home. He reiterates by saying "we still find that we learn habits of dependence by growing up in a culture which teaches a sense of personal inadequacy, a reliance on external bulwarks, and a preoccupation with the negative or painful rather than the positive or joyous" (p. 6).

Wilson Schaef (1986) provides one of the most comprehensive theories of co-dependency and concurs with much of what Peele has proposed. She argues that co-dependency arises from a disease process which she terms 'The Addictive Process' (p. 21). This is

> an unhealthy and abnormal disease process, whose assumptions, beliefs, behaviors, and lack of spirituality lead to a process of nonliving that is progressively death-oriented (p. 21)

that Wilson Schaef argues is endemic in society and is promoted through not only the family but institutions such as the church and schools.

Schaeffer (1987) agrees that the process of becoming a co-dependent may occur through the socialization process; she argues, however, that the inclination to be dependent on others is inherent in humans. She writes, "the need to be close to other people - the yearning to be special to someone - is so deeply ingrained in people that it may be called biological" (p. 13). She believes that if the infant child receives tension reduction (of its physical needs), he or she will learn to trust others and self. In Schaeffer's view, tension reduction and trust are the beginning of self-esteem and feelings of personal control. Should gratification of needs be lacking, the infant child feels physiological panic and learns to distrust others and self and fears separation; this puts in motion the move toward co-dependent behavior patterns.

Conclusion.

The literature appears consistent that co-dependent behaviors are derived from a dysfunctional family environment. Some reviewers focus upon co-dependency as specific to alcohol and chemical dependency. Other reviewers emphasize that co-dependency occurs in any dysfunctional family system. Still other writers in the field theorize that the learning of co-dependent behaviors is inherent in our society. Although these

theoretical discussions are of interest, they are not easily resolved and are beyond the scope of this present paper. For our purposes, co-dependency is defined as

> an emotional, behavioral and psychological pattern which develops as a result of prolonged exposure to and practice of a dysfunctional set of family rules. In turn, these rules make difficult or impossible the open expression of thoughts and feelings. Normal identity development is thereby interrupted (Subby, 1987, p. 84)

Dynamics of Dysfunctional Environments

Although an array of opinions are held regarding the etiology of co-dependency, there is clear consensus that the dynamics of such environments result in oppressive rules of conduct which promote co-dependent behaviors. Subby (1987) summarizes this well when he writes

> co-dependency can emerge from any [in italics] family system where certain overt (spoken) and covert (unspoken) rules exist -- rules that interfere with the normal process of emotional, psychological, behavioral and spiritual development. Rules that close off and discourage healthy communication, rules that eventually destroy a person's ability to form a trusting relationship within themselves or between others (p. 15).

These rules include: denial of problems, denial of feelings, both in terms of identifying feelings as well as expressing them, triangulated communication patterns, lack of consistent role models, external referenting and lack of encouragement to find pleasure (Subby, 1987).

Characteristics of Co-dependents

The focus of this present research is directed toward the behavioral patterns typically ascribed to the co-dependent person. By so describing, co-dependency becomes more sharply focussed and defined such that the concept can be operationalized.

A two-year perusal of the literature resulted in the selection of eighteen articles or monographs based upon either the comprehensiveness of the description of the characteristics and/or the unique contribution each made. Closer analysis revealed that seven did not meet these criteria and were subsequently removed.

Arising from an analysis of this body of literature, 117 descriptors were noted. Of these, several were considered by the originating authors to be characteristics of major importance to an understanding of co-dependency with the remainder being subsumed as descriptors of them. There is, however, a lack of consensus regarding which characteristics are paramount and which descriptors fit under what major headings. As well inconsistencies in language usage abound; for instance, Wilson Schaef (1986) includes "lack of boundaries" (p. 45) under a description of "external referenting" (p. 44) whereas Beattie (1987) describes "weak boundaries" (p. 42) as a characteristic of co-

dependency in and of itself. To further complicate matters, many of the descriptors have applicability to more than one major characteristic. Consequently, an analysis is not clear-cut and therefore subject to logico-deductive methods.

There are, however, characteristics within this body of literature which are consistently mentioned, whether it be in a major or descriptive capacity. Collectively, these describe individuals who have experienced little individual growth as a consequence of long-term exposure to a dysfunctional environment. Theirs was a socially isolated existence which resulted in a loss of reality checks (Mendenhall, 1989a; Schaeffer, 1987), a lack of knowledge of what constitutes "normal" behavior (Mendenhall, 1989a; Subby, 1987; Woititz, 1983) and feelings of being different from others (Beattie, 1987; Smalley & Coleman, 1987; Woititz, 1983). These characteristics are categorized as follows: little individual growth, external locus of control, low self-esteem, relationship addict, fear of abandonment, intimacy difficulties, control, limited range of emotions, loss of morality, lack of personal boundaries, physical illnesses and other addictions.

External Locus of Control.

While not all sources explicitly describe an external locus of control as a keynote characteristic of co-dependency, it is implicit in their descriptions. More commonly referred to as external referenting (Smalley & Coleman, 1987; Wilson Schaef, 1986; Woititz, 1983), co-dependents are dependent upon others to give them their sense of identity (Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; McConnell, 1986; Wilson Schaef, 1986). Beattie notes that co-dependents express an opinion only after determining what others want to hear. They lack emotional and/or behavioral independence and rely on others to supply these needs (Beattie, 1987; Subby, 1987). Co-dependents do not trust their perceptions (Mendenhall, 1989b; Beattie, 1987; Smalley & Coleman, 1987; McConnell, 1986; Wilson Schaef, 1986) and therefore are hypervigilant of others to confirm/deny their views (Mendenhall, 1989b; Subby, 1987; Beattie, 1987; Schaeffer, 1987; Cermak, 1986). This leads to procrastination (Woititz, 1983) and a reactive, rather than proactive approach to life (Mendenhall, 1989a). As well, co-dependents obtain their sense of value from outside themselves; consequently, they need to be needed by others and to feel indispensable to them (Beattie, 1987; Schaeffer, 1987; Subby, 1987; Wilson Schaef, 1986).

They have a constant need for approval and affirmation from others (Beattie, 1987; Subby, 1987; McConnell, 1986; Wilson Schaef, 1986; Woititz, 1983).

Low Self-Esteem.

Co-dependents feel a lack of personal worth (Mendenhall, 1989b; Beattie, 1987; Subby, 1987; McConnell, 1986; Woititz, 1983) which exemplifies itself, as indicated earlier, in a need to be needed and feel indispensable to others. This leads to their role being one of caretaker to others (Beattie, 1987; Cermak, 1986a; Wilson Schaef, 1986). As well, a feeling of low self-esteem manifests itself in an inability to accept criticism (Beattie, 1987), feelings of insecurity (Woititz, 1983), perfectionism (Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; Wilson Schaef, 1986; Woititz, 1983) and being judgemental of self and others (Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; McConnell, 1986; Wilson Schaef, 1986).

Relationship Addict.

Another characteristic important to an understanding of co-dependency is that co-dependents tend to be relationship addicts (Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; Wilson Schaef, 1986). They have multiple dysfunctional partners (Mendenhall, 1989a; Beattie, 1987) who are personality disordered, chemically dependent, co-dependent

and/or impulse disordered (Beattie, 1987; Cermak, 1986; McConnell, 1986). Schaeffer (1987) suggests that these choices may be part of a need to recreate old, negative, familiar feelings learned while living in the originating dysfunctional family. Co-dependents tend to become consumed with relationships (Schaeffer, 1987) and, as part of this, become involved in all aspects of the lives of people important to them (Beattie, 1987; Subby, 1987; Wilson Schaef, 1986). They tend to have a distorted view of the quality of their relationships (Smalley, 1987). Having partners they view as weaker than themselves boosts a co-dependent's sense of self. As well they feel they are needed to help the partner and as Schaeffer (1987) indicates, co-dependents attempt to change their mates.

As these relationships are crucial to a co-dependent's sense of well-being, they are extremely gullible (Beattie, 1987; Wilson Schaef, 1986), loyal to the point of foolhardy (Mendenhall, 1989b; Beattie, 1987; Subby, 1987; Cermak, 1986; Wilson Schaef, 1986; Woititz, 1983), and feel responsible to meet the needs of others to the exclusion of their own (Mendenhall, 1989a; Mendenhall, 1989b; Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; Cermak, 1986; Wilson Schaef, 1986; Woititz, 1983).

Fear of Abandonment.

Co-dependents fear abandonment by those individuals for whom they care (Mendenhall, 1989b; Schaeffer, 1987; Cermak, 1986; McConnell, 1986; Wilson Schaef, 1986; Woititz, 1983). Schaeffer (1987) notes that co-dependents fear letting go of relationships. As a consequence of the domination of this fear in their lives, co-dependents are incapable of healthy, intimate relationships and tend to rely on controlling these individuals in the hopes that abandonment will not occur (Woititz, 1983).

Intimacy Difficulties.

Co-dependents are incapable of, or have difficulty with, healthy intimate relationships (Mendenhall, 1989b; Beattie, 1987; Schaeffer, 1987; Smalley & Coleman, 1987; Subby, 1987; McConnell, 1986; Woititz, 1983). Schaeffer (1987) notes that co-dependents demand unconditional love, but refuse to commit themselves; they desire, yet fear, closeness.

Control.

Co-dependents attempt to protect themselves by controlling their external world. Consequently, they direct a great deal of their energies toward controlling self and others (Mendenhall, 1989b; Beattie, 1987; Subby, 1987; Cermak, 1986; McConnell, 1986; Wilson Schaef, 1986; Woititz, 1983). This control takes the form of helplessness, guilt, coercion, threats, advice-giving, manipulation and domination (Beattie,

1987) and compulsive behavior patterns (Mendenhall, 1989b; Subby, 1987; McConnell, 1986). Their need is to be involved in all aspects of a significant other's life (Beattie, 1987; Subby, 1987; Wilson Schaef, 1986). Control allows co-dependents to avoid conflict (Subby, 1987).

Beattie (1987) observes that co-dependents worry about unimportant issues and Schaeffer (1987) notes that they play psychological and power games. Due to the control co-dependents exert, they appear to be strong individuals; however, this is, in fact, surface maturity (Mendenhall, 1989b; Smalley & Coleman, 1987; Subby, 1987).

Limited Range of Emotions.

Co-dependents are unable to identify their feelings and express them (Mendenhall, 1989a; Mendenhall, 1989b; Beattie, 1987; Subby, 1987; Cermak, 1986; Wilson Schaef, 1986). They tend to be confused in their thinking about themselves and others (Mendenhall, 1989b; Beattie, 1987; Subby, 1987). They are serious (Beattie, 1987; Subby, 1987; Woititz, 1987) and intense (Mendenhall, 1989b; McConnell, 1986).

Beattie (1987), Smalley and Coleman (1987) and McConnell (1986) note that co-dependents have mood swings which Mendenhall (1989b), Beattie (1987), Subby (1987) and McConnell (1986) describe as excessive over- and under-reaction.

Mendenhall (1989b) observes that co-dependents feel unhappiness, despair and helplessness and are either anger

phobic or anger addicted; as well, Beattie (1987) indicates co-dependents feel unappreciated and used. In addition, shame and guilt about childhood and self are common emotions which co-dependents experience (Mendenhall, 1989b; Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987).

Morality Issues.

Co-dependents tend to compromise their values in order to maintain their relationships (Beattie, 1987; Cermak, 1986; Wilson Schaef, 1986). As Mendenhall (1989a) succinctly puts it, co-dependents have a tolerance for inappropriate behavior. As well, they deny that they have problems, both to themselves and when confronted to others (Mendenhall, 1989b; Beattie, 1987; Schaeffer, 1987; Subby, 1987; Cermak, 1986; McConnell, 1986; Wilson Schaef, 1986; Woititz, 1983).

Lack of Personal Boundaries.

Co-dependents are unaware of their personal boundaries (Mendenhall, 1989b; Beattie, 1987; Schaeffer, 1987; Smalley & Coleman, 1987; Subby, 1987; Cermak, 1986). Wilson Schaef (1986) describes this as a lack of awareness of feelings and thoughts. This leads to the co-dependent "tak[ing] on another's sadness, happiness, fear, or whatever people around them are feeling and/or thinking" (p. 46). Cermak (1986) notes the co-dependent actually feels the emotions of others rather than merely being empathetic to them.

Physical Illnesses.

Co-dependents are subject to a number of physical illnesses, predominantly stress-related. They tend to suffer from anxiety, depression, bulimia, nervosa and overeating (Mendenhall, 1989b; Beattie, 1987; Subby, 1987; Cermak, 1986; McConnell, 1986; Wilson Schaef, 1986).

Addictions.

In addition to being addicted to relationships, co-dependents tend to be involved in other addictions which include food, work, spending, licit and illicit drugs (Beattie, 1987; Subby, 1987; Cermak, 1986; McConnell, 1986). McConnell (1986) notes that co-dependents are excitement addicts which may account for their intolerance for delayed gratification (Subby, 1986) and the fact they they feel bored if there is no crisis in their life (Beattie, 1987).

Miscellaneous.

There are descriptors mentioned in the literature which cannot be readily categorized. Schaeffer (1986) notes that co-dependents are sadomasochistic. They may also be suicidal (Subby, 1987; Woititz, 1983), physical abusers (Mendenhall, 1989a; Beattie, 1987), have sexual problems (Beattie, 1987; Smalley & Coleman, 1987; Subby, 1987; McConnell, 1986) and suffer from mental illnesses (Beattie, 1987).

Conclusion.

Through use of the logico-deductive method, 117 descriptors have been culled from the literature. These have been assigned to fourteen major categories with the remaining descriptors subsumed under these fourteen headings (Appendix A). Included as one of the fourteen major categories is the etiology of co-dependent behaviors as described earlier in this chapter. One of the fourteen categories - "Little Individual Growth" - is included in the text as part of the introduction to the characteristics of co-dependency. As well, five descriptors have remained unclassified under the major heading of "Miscellaneous". Collectively, these are seen as providing a basis for understanding the many facets of co-dependency and, as far as this present study is concerned, will be the central constructs around which the diagnostic tool will be created.

CHAPTER III

Construction of the Individual Outlook Test

Introduction

While the co-dependent literature is rich, no attempts were made in it to provide quantitative evidence to support the existence of co-dependency as a diagnosable entity. Through systematically culling the content of this literature, a number of descriptors were obtained. These formed the basis of the items for the Individual Outlook Test which was subsequently subjected to the psychometric rigor necessary to create a valid, reliable diagnostic instrument.

Item Preparation

A review of eleven monographs or journal articles, selected for either the comprehensiveness and/or unique contribution of each, was conducted. From this review, 117 descriptors were noted and grouped under 14 main categories. These descriptors subsequently served as the basis of the items for the test. The number of items allocated to each descriptor topic was determined by the frequency with which it was mentioned in the literature review. For instance, `need to recreate old, negative feelings' is mentioned by only one author (Schaeffer, 1987), whereas `control' is described by the majority of them (Mendenhall, 1989b; Beattie, 1987; Subby, 1987; Cermak, 1986; McConnell, 1986; Wilson Schaef, 1986, Woititz, 1983); consequently, fewer items pertain to the

former, while a greater number are concerned with the latter. Nineteen items forced a negative answer to ensure that a fixed response set did not occur. A pool of 174 items was initially prepared.

To ensure readability of the items down to and inclusive of a grade 8 education, a small group of grade 8 students were asked informally to review them. Their reactions and comments served as the basis for revision and/or rejection of items.

Content Validity

After this procedure, 174 items of the original items remained. These were submitted to three judges familiar with the concept of co-dependency. Items which the judges were unable to categorize as being representative of the 14 descriptor topics were rejected and/or modified with the judges' assistance.

An initial version of the IOT was then prepared consisting of what appeared to be the most content-specific items.

There were 100 items in this first version, with 13 forced negative items interspersed throughout to combat agreement-response set.

Appendix B contains a copy of this initial 100 item version of the IOT.

Scoring Procedure

The directions called for responses to be recorded on a five-point Likert-type scale on a separate computer scanned answer sheet. The scoring procedure established utilized weightings of 5, 4, 3, 2, and 1 from strongly agree to strongly disagree on all items but the 13 designed to avoid response-set bias where the weightings were reversed. These reverse weightings were accounted for at the time of data analysis and altered accordingly. A high score, therefore, reflected a co-dependent orientation.

Item Analysis Procedure

Subjects - Norming Group.

The initial version of the IOT was administered to 178 individuals who volunteered to participate. These individuals ranged in age from 19 to 67. Of the 178, there were 110 females and 68 males. Several populations were sampled including an undergraduate class in educational psychology (n=47) and a class of students at a private marketing and administration college (n=24). In addition, through various random contacts, subjects were acquired from such diverse communities as Edmonton, Calgary, Crooked Creek, Millet, and Ponoka. The criteria for inclusion of these random contacts was that the subjects be over the age of 18 years and be non-students. The subjects, as far as possible, represented a stratified sample along socio-economic lines.

Procedure.

Subjects were asked to complete the initial form of the 100 IOT by placing their answers on a computerized scanning sheet and to complete a demographic information sheet which asked for a name or codename, age, date of birth, gender, occupation of subject, and occupation of subject's parents.

To ensure a stratified sample, representative of the total socio-economic spectrum, data for the Blishen Scale (1976) was collected. This yielded a three-digit socio-economic status number. Where an individual listed occupational status present and historically as `student', the parent's occupation was employed. For those subjects 25 years of age and younger who listed their occupation as `student', the parent's occupation was used as it was felt this represented a more accurate portrayal of the student's long-standing socio-economic status. In those situations where a subject was over the age of 25 and listed present occupational status as `student' but had been employed prior to `student' status, their occupational status prior to student status was used. Where the parent's occupation was used and both parents worked, an extrapolation was made between the two Blishen scores. Where a subject over the age of 25 listed `unemployed' under occupational status, the parent's occupation was used.

The demographic data was transferred to the computerized scanning sheet on which the subjects had placed their answers to the 100IOT. This data was then subjected to computer analysis, specifically to ascertain if a representativeness along socio-economic lines had been achieved. The resultant mean (M = 48.51) and standard deviation (S.D. = 14.03) for the Blishen Scale were found to be acceptably close to the figures (M = 51.63, S.D. = 11.0) for the City of Edmonton as reported by Elley (1961) for a random sample of 400.

Final Item Selection.

The data (n = 178) were subjected to an item-total correlation (Pearson Product Moment) analysis (Appendix C) and an item response frequency analysis. At the .01 level (r crit = .230), 75 items were found to be significant and at the .05 level (r crit = .164), 82 items were found to be significant. As a diagnostic test of this length was deemed to be unwieldy, the correlation criteria for inclusion was raised to r = .3. This reduced the number of items to 58. The additional criteria for inclusion that each item have a mean range on the Likert scale between 1.5 and 4.5 and a standard deviation range between 1.0 and 1.5 reduced the number of items for inclusion to 57. As insufficient items designed to avoid response set bias remained, three items, significant at the .05 level but below the .3 correlation cut-off were included.

The final version of the test has a total of 60 items with six of the items designed to avoid agreement response set bias.

The Final 60-Item IOT

The final version of the 60-Item IOT (Appendix D) was administered to a total sample of n = 107. This sample consisted of a class of graduate students in an education psychology course (n = 17) and random contacts (n = 90) from a variety of Alberta communities including Edmonton, Sherwood Park, Ponoka and Warburg. The criteria for inclusion was that the subjects be over the age of 18 and, in the case of the random contacts, be non-students. Subjects were asked to complete the 60IOT by placing their answers on a computer scanning sheet.

Demographic data for this sample was solicited and included a name or codename, age, date of birth, gender, occupation of subject and occupation of subject's parents. This data revealed that this sample consisted of 70 females and 37 males with an age range of 22 to 74 years.

For norming purposes, data for the Blishen Scale (1976) was collected. This data yielded a three-digit socio-economic status number. The criteria employed to ascertain this number was identical to that used for establishing representativeness of the 100IOT. Consequently, where an individual listed occupational status present and historically as `student', the parent's occupation was employed. For those

subjects 25 years of age and younger who listed their occupation as `student', the parent's occupation was used as it was felt this represented a more accurate portrayal of the student's long-standing socio-economic status. In those situations where a subject was over the age of 25 and listed present occupational status as `student' but had been employed prior to `student' status their occupational status prior to student status was used. Where the parent's occupation was used and both parents worked, an extrapolation was made between the two Blishen scores. Where a subject over the age of 25 listed `unemployed' under occupational status, the parent's occupation was used.

The demographic data was transferred to the computerized scanning sheet on which the subjects had placed their answers to the 60IOT. This data was then subjected to a number of statistical strategies.

Results indicated that the sample mean (M = 48.08) and standard deviation (S.D. = 14.11) for the Blishen scale were acceptably close to the figures (M = 51.63, S.D. = 11.0) for the City of Edmonton as reported by Elley (1961) for a random sample of n = 400.

In addition, an analyses of the responses to the 60IOT was conducted. As with the 100IOT, the responses were recorded on a five-point Likert-type scale. The scoring procedure established utilized weightings of 5, 4, 3, 2, and

1 from strongly agree to strongly disagree on all items but the 6 designed to avoid response-set bias where the weightings were reversed at time of scoring. A high score, therefore, reflected a co-dependent orientation.

The analysis revealed a total group (n = 107) mean and standard deviation of 158.15 and 26.98 respectively, a female group (n = 70) mean and standard deviation of 156.59 and 27.31 respectively and a male group (n = 37) mean and standard deviation of 161.11 and 26.48 respectively.

Validity Considerations

The content validity of the initial 100-item instrument and by extension the 60-item instrument was established:

1. through adherance to the specific content described in the literature
2. through acceptance of only those items upon which three competent judges were in accord

The criterion validity was established:

1. through a criterion group testing as per Chapter IV. Essentially, a group of counsellees diagnosed as co-dependent or collaterals in an alcohol addicted family or dyad were compared to a sample of normals. The comparison, of course, was via the 60 item IOT.

Reliability Considerations

Test-Retest.

A sample of graduate students (n = 10) in an education psychology course were administered a test-retest on the 60 IOT at a three to four-week interval with a resulting reliability correlation coefficient (Pearson Product Moment

Correlation Coefficient) of r = .89 and a Standard Error of Measurement of .33.

Internal Consistency.

In addition, the response data for the graduate students and the random contacts (n = 107) was analyzed for internal consistency (Cronbach's Alpha Coefficient). The resultant correlation coefficient was r = .88.

CHAPTER IV

Procedure and Design

Establishing Additional Validity

Introduction

The logical next step is to begin further validity considerations. The following discussion revolves around the continued establishment of a validity network for the IOT.

Sample

A group of individuals (n = 18) receiving treatment for co-dependency at two outlets of a local alcohol and drug treatment agency volunteered to complete the 60IOT and to provide the requisite demographic data. These individuals ranged in age from 25 to 54 years and were all female. They were receiving treatment voluntarily and, at the time of testing, had completed an 8 or 12 session co-dependency workshop which met once a week. These individuals were referred to the program after being assessed by experts at the agency as co-dependents, or collaterals, a term the agency uses to describe co-dependents.

Methodology

These subjects were matched with a sample (n = 18) from the norming group (n = 107) along age, gender and socio-economic status lines. The sample from the norming group were all female and ranged in age from 24 to 70 years. The Blishen score for socio-economic status for both groups ranged from

23.0 to 70.9 with a mean and standard deviation of 46.71 and 13.45 for the co-dependent group and 46.83 and 13.62 for the sample group.

After matching, the test scores for the two groups were calculated and subjected to statistical analyses.

Results

An dependent measures t-test (weighted means) comparing means for the norming group with the matched sample from the norming group was administered. Table 1 indicates that the matched sample was not significantly different from the norming group. In other words, the sample from the norming group was representative of the norming group.

Table 1

Comparison of the Means of Scores of the Matched Sample (Normals) and the Norming Group

Groups	N	Mean	S.D.	Degrees of Freedom	T	P two-tail)
Matched Sample	18	156.0	22.21			
				17	-.382	.7071
Norming	107	158.15	26.98			

An independent measures t-test (weighted means) comparing means for the norming group and for the co-dependent group was administered. It may be noted in Table 2 that the co-dependent group was found to be significantly different from the norming group.

TABLE 2

Comparison of the Means of Scores of the Co-dependent Sample and the Norming Group

Groups	N	Mean	S.D.	Degrees of Freedom	T	P (2-tail)
Co-dependents	18	179.83	40.68			
				17	2.277	.036
Norming	107	158.15	26.98			

A dependent measure t-test for means for the matched groups of co-dependents and sample from the norming group was completed. The data in Table 3 shows these two groups to be significantly different from each other. In other words, the co-dependent group scored higher on the 60IOT than the matched sample from the norming group.

TABLE 3
Comparison of the Means of Scores
of the Matched Sample from the
Norming Group and the Co-dependent Group

Groups	N	Mean	S.D.	Degrees of Freedom	T	P (two-tail)
Matched Sample	18	156.0	22.21			
				17	2.235	.0391
Co-dependents	18	179.83	40.68			

Conclusion

Thus, it may be concluded that the final 60IOT is a valid measure of co-dependency in that a sample of professionally diagnosed co-dependents scored significantly higher than a matched sample of "normals" on the test. This may be construed as criterion-referenced validity as well as predictive validity. Additionally, as mentioned at the outset of Chapter IV, this procedure has begun to add to the construct validity network surrounding the 60IOT.

CHAPTER V

Discussion and Implications

Introduction

Some possible reasons for obtaining the various findings is offered in the discussion to follow. Thereafter, the implications for the use of the 60IOT for therapy and for research are explored.

Discussion

The research project, described in this thesis, represents an amalgam of the fundamental building blocks required to create a diagnostic tool. While much more is required in terms of the establishment of a validity network, the initial results obtained herein are totally confirmatory of the structure of the 60IOT.

Most noteworthy is the difference in means on the 60IOT for the co-dependent group and a representative matched sample of the norming group. While more testing of diagnosed co-dependents is required to ascertain how well the 60IOT predicts the existence of co-dependency, the initial results lend support for the notion of co-dependency as a diagnosable entity. These results must be interpreted with caution as the sample of co-dependents used in this research project were individuals who had received treatment for co-dependency; it is possible they may not be representative of untreated co-dependents.

In addition, it must be noted that, while the present researcher predicted that co-dependency would exist as a psychological construct, the question still remains as to whether or not this prediction is of an enduring, stable set of behaviors. It may still be found to be a transitory state, reactive to environmental circumstances. It would be interesting to obtain a sample of individuals pre-treatment and compare them to a post-treatment group as well as pre- and post-test the same group.

It is not surprising that the test-retest reliability coefficient for the 60IOT is high. The small sample size and the short time between tests, combined with the fact that the group was fairly homogeneous and highly intelligent, would tend to create a high coefficient. Nonetheless, it remains a valid estimate of test-retest reliability, although it is likely that further testing on more heterogeneous groups would reveal a somewhat lower estimate.

Implications for Practice

The practical application of the 60IOT in clinical settings are numerous. As a diagnostic tool, the 60IOT may assist the clinician knowledgeable in the area of co-dependency to a more accurate diagnosis. The 60IOT may also act to more fully inform those clinicians not familar with the area of co-dependency, as well as provide a more accurate diagnosis. In addition, the 60IOT may be used as an

educational tool through the comparison of norms and individually obtained scores for those individuals who display co-dependent behavior patterns, but who are resistant to therapy for same. As well, informal reporting by co-dependents who have taken the 60IOT indicate that the questions are thought-provoking; this lends support for the use of the answers to the items on the test as subject matter in a therapeutic dyad.

Lastly, and most salient, diagnosis of co-dependency has been removed from the realm of clinical impressions to one based upon scientific rigor. This can only serve in the best interests of the clients in that the probability of misdiagnosis is reduced.

Implications for Further Research

As is well understood by those who construct psychometric tools, establishment of a validity network around a newly-created test is an ongoing process. Such is the case with the 60IOT which is in its infancy in terms of development. Suggestions for further research to expand validity considerations revolve around further norming, convergent validity, divergent validity, factor analysis and broadening validity into allied contexts.

Norming

The subjects who participated in the establishment of the items for the 60IOT and in the initial norming phase were, for

the most part, Caucasian. Establishment of cross-cultural norms would allow comparisons within and between groups. As well, a larger sample pool for male norms is needed in order to ascertain if gender differences exist as depicted in these results.

Convergent Validity

Further support for the co-dependency construct may be obtained through the concurrent administration of the 60IOT and/or the Potter-Efron (1989) and Friel (1985) co-dependency questionnaires.

Divergent Validity

It is important to reduce the possibility that the 60IOT is measuring a construct or constructs that are not of interest. Two obvious examples, English language abilities and intelligence, could be eliminated through the concurrent administration of the 60IOT and English and I.Q. tests (APA Standards, 1985).

Factor Analysis

This present research identifies 14 major categories of descriptors, with one of the 14 being the classification of 'miscellaneous.' A factor analysis of responses to the items on the 60IOT would ascertain the saliency of the items and ultimately the number of independent factors which constitute co-dependency. These new factors would subsume the 14 main categories used in this present research project.

Broadening Validity into Allied Contexts

For this study, the researcher used a co-dependent sample of individuals seeking treatment within an alcohol or chemically dependent context. According to the literature, co-dependent behaviors may arise from other dysfunctional environments. It would be enlightening to administer the 60IOT to individuals who have had long-term exposure to other dysfunctional environments. Victims of sexual abuse and individuals raised in a family with a chronically ill member are two possible areas for further exploration.

Conclusion

We have shown that the 60IOT can be used to delineate persons who exhibit the co-dependency psychological trait. The final 60-item version has been shown to have internal consistency, test-retest reliability and to possess predictive validity, convergent validity and construct validity. It is the first psychometrically derived measure of co-dependency to be placed in the research domain and many clinical, remedial and research directions have been opened.

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APPENDIX A

LIST OF DESCRIPTORS

1. Etiology

   - alcohol/chemical dependent family
   - sick, disturbed or troubled family members
   - repressive, oppressive family system
   - physically abusive family system
   - sexually abusive family system
   - rigid, dogmatic family system
   - compulsive gambling in family system
   - compulsive sexual activities in family system
   - eating disorders
   - existence of family secrets
   - existence of chronic diseases
     - schizophrenia
     - diabetes
     - Alzheimers
     - mental retardation
   - existence of workaholic family members
   - existence of professionals who work with addictions
   - existence of neurosis
   - families that do not foster autonomy
   - families that reward learned helplessness
   - presence of co-dependent behavior patterns
   - cultural institutions
     - advertising
     - media
     - church
     - schools
   - gratification of unmet physiological needs

2. Little Individual Growth

   - socially isolated existence
   - loss of reality checks
   - uncertain of what "normal" behavior is
   - feelings of differentness from others

3. External Locus of Control

   - external referenting
   - rely on others to give sense of identity
   - express opinion after determining what others want to hear
   - lack emotional and/or behavioral independence
   - rely on others to supply emotional needs

do not trust their perceptions
hypervigilant of others to confirm/deny their views
procrastinators
lead a reactive, rather than proactive lifestyle
obtain sense of value from others
need to be needed by others
need to feel indispensable to others
constant need for approval and affirmation from others

4. Low Self-esteem

feel lack of personal worth
role of caretaker
inability to accept criticism
feelings of insecurity
perfectionistic
judgemental of self and others

5. Relationship Addict

have multiple, dysfunctional partners
  personality disordered
  chemically dependent
  co-dependent
  impulse disordered
need to recreate old, negative feelings learned in originating family
become consumed with relationships
become involved in all aspects of lives of others
have a distorted view of quality of relationships
have partners whom they view as weaker than themselves
feel needed to help the partner
attempt to change their partner
gullible
loyal to the point of foolhardy
feel responsible to meet the needs of others to the exclusion of their own

6. Fear of Abandonment

fear letting go of relationships
rely on controlling individuals to avoid abandonment

7. Intimacy Difficulties

incapable of healthy, intimate relationships
demand unconditional love

refuse to commit themselves
desire, yet fear, closeness

8. Control

concentrate on control of self and others
helplessness
guilt
coercion
threats
advice-giving
manipulation
domination
compulsive behavior patterns
attempt to avoid conflict
worry about unimportant issues
play psychological and power games
give appearance of being strong individuals
surface maturity

9. Limited Range of Emotions

unable to identify their feelings and express them
confused thinking
serious
intense
mood swings
excessive over- and under-reaction
unhappiness
despair
helplessness
anger phobic or anger addicted
feel unappreciated and used
shame
guilt

10. Morality Issues

compromise values in order to maintain relationships
tolerance for inappropriate behavior
denial of problems, both to self and others

11. Lack of Personal Boundaries

unaware of personal boundaries
lack of awareness of feelings and thoughts
take on others emotions
actually feels others emotions

12. Physical Illnesses

anxiety
depression
bulimia
nervosa
overeating

13. Addictions

food
work
spending
licit drugs
illicit drugs
excitement
intolerance for delayed gratification
boredom if no crisis

14. Miscellaneous

sadomasochistic
suicidal
physical abusers
sexual problems
mental illness

APPENDIX B

100 ITEM IOT FORM

1. I am attracted to occupations like social work, nursing and volunteer work.
2. I always take time to do something for myself.
3. In a group of people I am embarrassed if I am asked to give an opinion.
4. I have had romantic partners that I felt I could help.
5. I like uncertainty and unpredictability.
6. I fall in love easily.
7. I seldom worry about what I need or feel.
8. I sometimes feel that I'm not good enough to associate with the people I meet.
9. I never try to help people unless I'm asked.
10. I have often done things without thinking them through properly and later regretted my decision.
11. I was raised in a family where the rules were extremely strict.
12. Praise or a compliment from someone will make me feel great for days.
13. I feel anxious or tense about something or someone almost all the time.
14. I have had partners who didn't treat me very well.
15. It seems to me I have spent my whole life trying to please others.
16. Although I appear strong and capable to others, there is a part of me that isn't strong at all.
17. I have on many occasions, checked up to see where my partner is when he or she is not with me.

18. When I want something, it doesn't bother me to have to wait to get it.

19. I have a tendency to try harder to help people rather than give up on them.

20. I have been close to people who did illegal things and I found excuses for what they did.

21. I prefer my life to constantly have something happening in it.

22. I sell myself short and settle for less than the best in romantic partners.

23. Often when asked for my opinion, I find out what other people think before I say what I think.

24. I am more strict about the right way to do something than most people.

25. I often feel there is something bad about me.

26. I can't remember the last time I felt totally carefree and relaxed.

27. Sometimes I don't know who the real me is.

28. I prefer to work at a job with clear rules to one where I have to find my way as I go along.

29. I never try to do what is expected of me by others.

30. When I'm in a relationship, most of my time is spent thinking and/or talking about my partner and our relationship.

31. I am constantly thinking of ways to improve the people I care about.

32. I like to take charge and know exactly what is happening at all times.

33. I often feel anxious and uptight and can't figure out why.

34. I sometimes associate with people who do things that are considered wrong.

35. I tend to believe things people say and often find out later that they have lied.

36. I feel I fit in at most social gatherings.

37. I feel best about myself when I'm having a romantic relationship.

38. My friends and family have been upset with me for staying with someone who treated me poorly.

39. Often, others find things amusing that I don't consider funny.

40. Even a small kindness from a person I've had a problem with makes me forgive and forget.

41. When I care about someone, I rarely get discouraged about them.

42. I don't undertake any project unless I'm pretty sure I'll succeed.

43. There are things I have done or had happen to me in the past that I am ashamed to talk about.

44. Many people come to me for help with their problems.

45. I have often said hurtful things to people I love in order to get them to listen.

46. I have never had casual sex.

47. I am embarrassed when people give me compliments but secretly I feel good.

48. I can be easily swayed from doing something if others criticize it.

49. I have never been physically abused by anyone.

50. I prefer my life when I know exactly what is happening in it at all times.

51. When things go wrong for others, I often blame myself even when I shouldn't.

52. When I am in a relationship, I am totally involved in it and expect the same from my partner.

53. It wouldn't bother me to live alone.

54. Everything I do, I try to do perfectly.

55. Quite often I lose sleep worrying about people who are important to me.

56. I have abused drugs prescribed by a doctor.

57. I am not ashamed of my childhood.

58. I feel I am more capable of making a better decision for others than they are for themselves.

59. I quite often feel as if something dreadful is going to happen.

60. When I feel I have insulted a person, I feel ill until I make the matter right.

61. I have trouble thinking of the right things to say when in a group of people.

62. I have lied to protect people who are important to me.

63. I was raised in a family where physical abuse occurred.

64. I need a lot of reassurance that people like me.

65. It is hard for me to ask for help from someone unless I know I can return the favor.

66. When even little things go wrong, I usually get very upset and stay upset until everything is fine again.

67. I was raised in a family where at least one member was an alcoholic or drug addict.

68. Often I feel so nervous and tense that I feel dizzy.

69. I rarely go out or do anything without my partner.

70. I am envious of most of the people I meet.

71. If I am embarrassed or feel foolish, I worry about it for days.

72. Somedays there seem to be so many things going wrong that life seems hopeless.

73. I had a happier childhood than most other people.

74. I don't worry very much about what the future holds for me.

75. I prefer no relationship to a relationship that is not going well.

76. I tend to overeat.

77. There have been times when I have deliberately used tears or acted unhappy in order to get my own way.

78. Sometimes I have so many thoughts racing through my head that I can't make sense out of them.

79. When I meet someone who has a problem, I often try to help them even before they ask.

80. If someone criticizes me, I tend to believe them and then try to change myself.

81. I have had romantic partners who have been alcoholics or drug abusers.

82. I have gone to see a doctor about my depression.

83. I often judge people without finding out all the facts.

84. I don't let people get to know the real me.

85. I have used illegal drugs.

86. I am never concerned about whether people like me or not.

87. There have been times when my life has seemed so depressing that I have thought of ending it.

88. As a child, my parents seldom listened to what I had to say or how I felt.

89. I do not like people criticizing me even if they may be right.

90. When I am alone, I often feel desperate to have company.

91. Most people cannot be truly trusted.

92. I have seen a doctor over not sleeping.

93. I tend to drink too much alcohol.

94. It bothers me if my romantic partner wants to go out or do something without me.

95. I have never been sexually abused.

96. I have done things I am not very proud of in order to keep a relationship together.

97. My feelings and behavior are mostly controlled by the people around me.

98. One of my greatest worries is that some of the people I care about may leave me.

99. I have extremely high standards for myself.

100. I often feel as if I haven't begun to live yet.

APPENDIX C

Item to Total Correlation (r) for 100IOT
Item Means and Standard Deviations (S.D.)

Item Number	Item-total Correlation (r)	Item Mean	Item S.D.
1	.15	3.21	1.27
2	.08	2.17	1.09
3	.27	2.22	1.29
4	.18	3.19	1.37
5	.07	3.48	1.18
6	.25	2.26	1.27
7	.09	2.35	1.22
8	.47	2.33	1.34
9	.21	3.99	1.07
10	.39	3.18	1.21
11	.20	2.83	1.36
12	.13	3.48	1.06
13	.55	2.42	1.24
14	.43	2.78	1.42
15	.49	2.92	1.30
16	.44	3.84	1.15
17	.39	1.97	1.27
18	.02	2.73	1.27
19	.23	3.74	1.04
20	.33	2.29	1.37
21	.04	3.61	1.21
22	.57	2.36	1.30
23	.43	2.54	1.26
24	.25	3.29	1.20
25	.58	2.48	1.22
26	.49	2.53	1.41
27	.61	2.57	1.32
28	.21	2.98	1.35
29	.15	3.91	.99
30	.23	3.21	1.89
31	- .26	3.53	1.71
32	.13	3.78	.99
33	.56	2.80	1.29
34	.26	2.64	1.39
35	.34	2.86	1.25
36	.29	2.38	1.19
37	.48	3.15	1.24
38	.43	2.26	1.51
39	.43	2.93	1.20

40	.35	3.16	1.22
41	.13	3.29	1.25
42	.32	2.96	1.15
43	.48	3.01	1.41
44	.05	3.87	.99
45	.36	2.57	1.27
46	.05	3.21	1.67
47	.45	3.21	1.32
48	.41	2.64	1.16
49	.37	2.80	1.27
50	.27	3.45	1.11
51	.44	2.38	1.26
52	.30	3.71	1.25
53	.11	2.45	1.38
54	.24	3.54	1.11
55	.42	3.03	1.31
56	.26	1.37	.96
57	.42	1.76	1.25
58	.25	2.35	1.16
59	.57	2.18	1.27
60	.32	3.44	1.11
61	.40	2.85	1.30
62	.36	3.22	1.16
63	.35	1.90	1.50
64	.59	2.81	1.24
65	.40	3.25	1.29
66	.56	2.32	1.20
67	.24	2.25	1.72
68	.51	1.81	1.26
69	.36	2.31	1.47
70	.50	1.89	1.07
71	.52	2.35	1.20
72	.65	2.36	1.30
73	.28	2.43	1.17
74	.32	3.50	1.26
75	.09	2.17	1.26
76	.28	2.55	1.41
77	.27	2.26	1.25
78	.47	2.85	1.32
79	.47	2.72	1.18
80	.38	2.46	1.03
81	.44	2.15	1.59
82	.36	1.86	1.45
83	.23	2.90	1.17
84	.35	2.67	1.24
85	.16	2.74	1.69
86	.29	3.48	1.08
87	.40	2.25	1.47
88	.31	2.76	1.50

89	.33	3.14	1.12
90	.42	2.29	1.23
91	.34	2.50	1.21
92	.24	1.71	1.29
93	.26	1.69	1.14
94	.61	2.15	1.23
95	- .15	3.71	1.74
96	.40	2.22	1.38
97	.62	2.20	1.13
98	.53	2.58	1.35
99	- .01	3.94	1.05
100	.54	2.79	1.36

APPENDIX D

60 ITEM IOT FORM

1. I sometimes feel that I'm not good enough to associate with the people I meet.

2. I never try to help people unless I'm asked.

3. I have often done things without thinking them through properly and later regretted my decision.

4. I feel anxious or tense about something or someone almost all the time.

5. I had a happier childhood than most other people.

6. I have had partners who didn't treat me very well.

7. It seems to me I have spent my whole life trying to please others.

8. Although I appear strong and capable to others, there is a part of me that isn't strong at all.

9. I have been close to people who did illegal things and I found excuses for what they did.

10. Often when asked for my opinion, I find out what other people think before I say what I think.

11. I often feel there is something bad about me.

12. I am not ashamed of my childhood.

13. I can't remember the last time I felt totally carefree and relaxed.

14. Sometimes I don't know who the real me is.

15. I have on many occasions, checked up to see where my partner is when he or she is not with me.

16. I tend to believe things people say and often find out later that they have lied.

17. I have trouble thinking of the right things to say when in a group of people.

18. I feel I fit in at most social gatherings.

19. I feel best about myself when I'm having a romantic relationship.

20. Often, others find things amusing that I don't consider funny.

21. Even a small kindness from a person I've had a problem with makes me forgive and forget.

22. I don't undertake any project unless I'm pretty sure I'll succeed.

23. There are things I have done or had happen to me in the past that I am ashamed to talk about.

24. I have often said hurtful things to people I love in order to get them to listen.

25. I am embarrassed when people give me compliments but secretly I feel good.

26. I can be easily swayed from doing something if others criticize it.

27. When things go wrong for others, I often blame myself even when I shouldn't.

28. I don't worry very much about what the future holds for me.

29. When I am in a relationship, I am totally involved in it and expect the same from my partner.

30. Quite often I lose sleep worrying about people who are important to me.

31. I quite often feel as if something dreadful is going to happen.

32. When I feel I have insulted a person, I feel ill until I make the matter right.

33. I sell myself short and settle for less than the best in romantic partners.

34. I have lied to protect people who are important to me.

35. I was raised in a family where physical abuse occurred.

36. I need a lot of reassurance that people like me.

37. It is hard for me to ask for help from someone unless I know I can return the favor.

38. When even little things go wrong, I usually get very upset and stay upset until everything is fine again.

39. Often I feel so nervous and tense that I feel dizzy.

40. I rarely go out or do anything without my partner.

41. I am envious of most of the people I meet.

42. If I am embarrassed or feel foolish, I worry about it for days.

43. Somedays there seem to be so many things going wrong that life seems hopeless.

44. Sometimes I have so many thoughts racing through my head that I can't make sense out of them.

45. When I meet someone who has a problem, I often try to help them even before they ask.

46. I am never concerned about whether people like me or not.

47. I have often gone to see a doctor about my depression.

48. I don't let people get to know the real me.

49. There have been times when my life has seemed so depressing that I have thought of ending it.

50. As a child, my parents seldom listened to what I had to say or how I felt.

51. I do not like people criticizing me even if they may be right.

52. When I am alone, I often feel desperate to have company.

53. Most people cannot be truly trusted.

54. It bothers me if my romantic partner wants to go out or do something without me.

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59. I often feel as if I haven't begun to live yet.

60. I often feel anxious and uptight and can't figure out why.